

# Primary medical care in Spain

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**SUMMARY.** *The extremely complex and rapidly but unevenly developing system of primary care in Spain is described. The health centre movement in Spain merits close attention, and could be a useful model for our own service.*

## Introduction

ALMOST unnoticed by British doctors, a legislative revolution has happened throughout southern Europe (Portugal, Spain, Italy and Greece) over the past five years, establishing the administrative and legal framework of national health services which in some ways resemble our own National Health Service. There is a wide gap between these new laws and their full implementation, and development is extremely uneven; but the atmosphere of hopeful innovation, mostly by young doctors, is obvious to any informed foreign observer. Of all these countries, Spain is probably the most advanced in terms of implementation of the laws.

## Political and economic background

Except for patches of industrialization in Catalonia, the Basque country and around Madrid, Spain had little developed industry until the 1960s. Liberal government institutions existed only from 1931 to 1939, and from then until 1976 Spain's society was frozen in a state modelled on Italian corporate fascism, a maze of microbureaucracies without either local democratic control or effective central planning. However, public medical services were an important part of Franco's attempt to broaden his social base, and medical care, retirement and welfare benefits were introduced for all industrial workers in 1942, with a major investment in high technology hospitals in the 1970s.

From about 1960 onwards industry developed rapidly, mainly from state-capitalist enterprises, foreign investment, investment of savings from workers abroad, and recklessly developed tourism. By 1986 Spain's per capita gross national product was over twice that of Portugal and a little more than half that of Italy and the UK. Franco's death in 1975 released movements for renewed social development and, particularly among young people, a will to reach general European standards of living, health and education as soon as possible, while retaining a vigorous national identity.

## The reforma sanitaria

Except for maternal mortality, which, probably because of illegal abortion, is the worst in Europe, mortality indices in Spain are relatively good — infant mortality is 10.5 per 1000 livebirths, life expectancy 76 years. However, these figures are deceptive. Spain is still a young country, in which most adults have grown up with a traditional mediterranean diet, and registered coronary mortality is still about 50% less than stroke mortality, though some of this difference may represent poor diagnostic accuracy.

The national diet is now moving toward the Northern pattern; smoking is very heavy (notably among doctors), and epidemics of lung cancer and coronary disease are likely to worsen over the next few decades as the population ages.

## Organization of public medical services

The narrow social base for private medical practice in Franco's Spain ensured that public medical provision developed independently and with relatively little effective opposition from the medical establishment. The first national medical insurance service (Seguridad Social) was set up in 1942 under Franco. It covered 93% of Spanish citizens by 1988, and supplied about 80% of all medical care. Private care accounted for another 3% of care, and charities (*beneficencias*) 1%.

The Seguridad Social has hitherto been based on monthly contributions; 40% by the employer and 60% by the employee, jointly providing 75% of funding. The remaining 25% came from general taxation, but since 1988 this has risen to 70% of health service costs. Officially recognized unemployment stood at 16.5% in February 1990, but this excludes those seeking work for the first time and most housewives. True unemployment during the past 10 years has never been less than 20%, and remains between 20% and 23% now, much higher in many areas; many of these people have never been able to make insurance contributions, but they are apparently accepted for care in both the *ambulatorios* and the health centres described below, with costs met as a charity by local government. By 1984 medical and health care of all kinds consumed about 6.6% of the gross national product, about the same as the UK.

All hospital care in the social insurance system is free. However, about 17% of hospitals operate for profit, partly from private patients who do not use the state system, but mainly by providing care under contract for the Seguridad Social. The church now has little control over hospitals. Psychiatric hospitals remain custodial and isolated from other health services, and are financed by provincial government. Dentistry was also isolated and grossly undermanned as a public service, the dental establishment having succeeded in maintaining its monopoly in a restricted and privileged market. Recently a dental career structure has been reformed so that dentists follow two separate paths. *Estomatologos* are recruited from medical graduates, with a further two years of expensive training, and have led a boom in private dentistry. *Odontologos* have five years training and no medical degree; the first of them will qualify in 1991.

The post-Franco constitution recognized access to medical care as a basic human right. As in other Latin countries, however, there has been a wide, potentially permanent gap between legislation and implementation, which has largely depended on regional political and professional initiatives. In 1986 a 'general law of health' was passed for an integrated national health service, including universal (though not necessarily free) primary care, and providing a legal alternative to the Seguridad Social — care by medical and nursing teams operating from health centres. This is financed partly from general taxation and partly from local taxes at different levels of local government. Consequently, the implementation of the health centre movement depends on the social orientation and energy of different regions and municipalities. It is now developing rapidly in some areas, hardly at all in others, parallel with the old Seguridad Social framework (the *ambulatorios*), but with the eventual aim of replacing it.

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### Medical education and medical unemployment

A huge expansion of secondary schooling greatly increased the number of qualified applicants for medical schools and all were accepted regardless of national needs until about 1978. For example, in 1976 a 1000-bed teaching hospital in Barcelona was admitting 2000 students a year. In 1982 there was roughly one medical student for every four registered doctors, and 46% of Spanish doctors are now under 30 years old. An increasing proportion, now 20%, are women and the proportion of women in health centre practice seems much higher. Action has now been taken to control entry, and medical school admissions in Barcelona were brought down to 300 a year by 1981 (still a ratio of about one student for each hospital bed).

In June 1983 there were 6000 unemployed doctors in Catalonia alone and in April 1988, medical unemployment was running at 32%. The largest and most conservative professional organization, the Organización Médica Colegial, estimated that in 1988 there were between 25 000 and 30 000 unemployed registered doctors in Spain, and another 10 000 to 15 000 who had not registered because they saw no hope of a job, around 40 000 in all. Overall, there are about 298 people for each doctor (employed or unemployed). Many employed doctors have several jobs, a situation resented by unemployed doctors and by the government, which naturally suspects that doctors paid for two or three different jobs are not doing any of them properly. A national law confining each doctor to a single salaried job was passed in 1987, but this applies only to state employment and many will retain various kinds of private practice which preclude wholehearted commitment to public service. The medical establishment has blamed the situation on low salaries, and there is a good deal of truth in this. I was chastened to discover that in 1988 an outstandingly competent medical director of a provincial primary care system earned about half as much (£15 000) as an average UK general practitioner, and a whole-time health centre doctor one third as much.

### General practice as a specialty

Residency programmes were developed rapidly in the 1970s, producing large numbers of specialists without hope of specialty employment. This led to strong trade union organization of young doctors. In 1978, prompted more by political than medical pressures, primary care was legally recognized as a specialty, with appropriate residency training. The minority of doctors who undertook this training then sought to develop primary care as a serious career specialty in its own right. Doctors trained recently in internal medicine who cannot get specialty employment now resent the fact that they cannot enter general practice without appropriate training, and friction exists between them and those who have been through the general practice residency programme.

Unlike the UK, where the reconstruction of general practice as a specialty was initiated entirely by general practitioners themselves, most of the first generation of Spanish doctors with a serious interest in the development of general practice originally had a background in internal or community medicine. In 1982 they formed the Spanish equivalent of the Royal College of General Practitioners, the Asociación Española de Medicina Familiar y Comunitaria, which has actively and consistently supported the reforms of the Spanish health service outlined below. The first residency programmes in family and community medicine were established in 1978–80 following the World Health Organization Alma-Ata declaration.

### Nursing

Nurses were originally provided by the church, but with the

extension of secondary schooling this labour supply collapsed. Nurses are now university trained, and there is a strong nurse practitioner movement. In 1988 there were 156 000 nurses in Spain, about 1.4 to each practising doctor, with an unemployment rate of 3%. Confusion and conflict persist even in health centres over divisions of labour between doctors and nurses. There is still no specialty training for nurses in primary care, but their attendance at and participation in professional meetings is impressive.

### Vocational training for general practice

Family and community medicine as a specialty began in 1980. A scheme modelled on the family medicine residency programme in the USA began in 1980, but with a greater emphasis on community medicine than in either the USA or the UK. It runs for three years; two years in hospital which include three months in a health centre, and one complete year in a health centre. Hospital training includes internal medicine and medical specialties, obstetrics and gynaecology, paediatrics, mental health and some surgery. A programme on public health, community medicine, epidemiology, environmental health and statistics continues throughout all three years. By 1988 this system had produced about 2500 general practitioners with postgraduate training, and 500–700 new trainees are now produced each year from 40 teaching health centres, with much competition for places because of the high level of medical unemployment. There is little continuing education except in teaching health centres, and nearly all of this is funded by pharmaceutical companies.

Development in the various autonomous regions is uneven. Spain's first teaching health centre was 'La Cartuja' in Andalusia, soon followed by centres in Barcelona (Hospitalet), Madrid, La Coruña and Bilbao.

### Nature of general practice

The level of private general practice is substantial in some areas. Though in Catalonia and Andalusia it seems as yet almost irrelevant for the mass of the population, it is evidently important in Madrid. An estimated six million people use private general practitioners, though many of these also attend the public services for the more administrative parts of their care. Private practice is growing in many areas because of the generally unsatisfactory quality of public service practice and the rising incomes of most employed people. A bitter struggle seems to be going on between those who still see private practice as the only possible growing point for better care, and those who believe the future must lie with team care from health centres with registered populations. There appears to be a serious and probably inevitable split between general practitioners attempting to develop better care by a combination of private practice and very part-time work in the Seguridad Social (two-hour sessions), and those working full-time in health centre teams. At present both the old and the new public systems of primary care described below co-exist, covering about 80% and 20% of the population, respectively.

### The old system: *ambulatorios*

In towns or cities with populations over 20 000, public service general practitioners usually work from large centres (*ambulatorios*) serving a population of about 200 000, or from small satellite centres (*consultorios*). Between 75% and 80% of the population were covered by this system in 1988, the proportion varying greatly between the various autonomous regions, being highest in the most industrialized regions of Madrid and Catalonia, and lowest in Galicia. It sounds like a neat system, but the areas defined for different administrative purposes are

not coterminous, and there is a chaotic referral system. General practitioners work in two-hour sessions at high speed, without effective records or continuity, and provide demand led care without any possibility of forward planning. There are no appointment systems and waiting areas are usually three or more times bigger than consultation and treatment areas. Premises are supplied by local government authorities, most of them resembling the worst type of concrete office block. The accounts I heard from young doctors who had worked in this system were of industrialized care, with shifts of doctors hammering on the door every two hours to take over a warm seat, and take their place at the assembly line. The rest of the day is filled with as much other work as doctors can find payment for. Many doctors have two or even three salaried jobs, as well as some private practice. For many if not most, public clinic work is a low priority, which is given as little time and attention as possible.

General practitioners are recruited to the *ambulatorios* by competitive examinations designed by hospital specialists and unrelated to primary care skills. Few of those recruited have postgraduate training either in family and community medicine, or in any hospital specialty. Their payment is by capitation, based on the number of 'insurance' cards held — from 700 to 1300 cards each. However, as many as five other householders or family members may be 'attached' to the same card, so that the real population at risk can vary from 1300 to 3500 for the same income and nominal list. The average number of 'attachments' varies, for example from less than two in the Basque country to more than three in Andalusia. The average real population at risk per general practitioner is 2500–3000.

The average national consultation rate is said to be about 5.3 encounters per patient per year; in Barcelona it is about 9.3 per patient per year. General practitioners are employed for two to two and a half hours a day seeing public insurance patients registered on their own lists, at a rate of 70–80 a day in Andalusia, and about 45 a day in Madrid. Consultation time is said to average three minutes. In different surveys, between 37% and 48% of consultations have been estimated to have an entirely bureaucratic content (certification of unfitness for work and so on). Despite the capitation system, there is no registration of the population, no preventive or outreach work is done, there is no teamwork, and no staff development programme or staff meetings.

Though general practitioners are nominally on call for their registered list until the evening, few seem to be actually available for house calls or emergencies. Most emergencies go directly to hospital emergency rooms, or are attended by a completely separate out-of-hours salaried medical service maintained in some cities. This may be well organized but there is no liaison with the *ambulatorios*.

### Specialoids and the referral system

The *ambulatorios* also contain specialists without hospital privileges (what John Fry aptly calls 'specialoids'), available both for primary and referred consultations. Spain has a complex three-tier referral system which presents bewildering differences from our own relatively simple two-tier system. Patients who register with a general practitioner simultaneously register with specialoids working from the same *ambulatorio*. These specialoids not only have no hospital beds, but as a rule have only limited rights to laboratory and radiological investigations carried out in the *ambulatorio*, not in a hospital. They usually include a paediatrician, an obstetrician-gynaecologist, internists or internist-subspecialoids (cardiologists, gastroenterologists, and so on), ophthalmic and ear, nose and throat specialists, and a neuropsychiatrist. The unit is also supported by one or two office staff, and a general-factotum nurse, who often remains present

throughout consultations.

The specialoids are seldom known personally to one another or to the general practitioners. This seems to be a consequence of the casual and uncommitted attitude of most doctors at all levels in the *ambulatorios*. Patients who do not like a particular specialoid must change their general practitioner in order to see someone else. These *ambulatorio* specialoids are the first line of referral for general practitioners. If patients need to see a hospital-based specialist, they are referred a second time by the specialoid.

Communication between these various professionals is bad, and inhibits referral by the keenest general practitioners because they then lose sight of their patients. The few records I have seen suggest very limited documentation and little communication. Hospital care seems to be isolated from primary care, and mainly crisis-oriented. Moves to reintegrate *ambulatorio* specialoids with the hospitals have been welcomed by them, but resisted by established hospital specialists.

Family practice in the sense of one generalist responsible for a whole family at all ages is not possible in the *ambulatorios* or in the health centres which aim to supersede them. Inclusion of child health as a central feature of British general practice is much envied by our Spanish colleagues. Up to the age of seven years (14 years in some health centres) all children are the responsibility of clinic-based paediatricians.

### Rural primary care

The Asistencia Publica Domestica was set up in 1953. Under this system rural areas with populations of 10 000 or less have been served by general practitioners working from public offices or their own homes. Most have worked in essentially the same way as urban general practitioners in the *ambulatorios*, but they have a 24-hour commitment, offer some preventive services, and generally have a more personal relationship with their patients. Posts have in the past been filled through a competitive state examination requiring no postgraduate training, but about 10% of rural general practitioners now enter through the same examination as health centre doctors; where this occurs, about two-thirds of rural general practitioners have postgraduate vocational training in family and community medicine.

Though most of the reforming initiatives in Spain have been in urban health centres, remarkable pioneering work also goes on in some rural areas, notably around Salamanca.

### Health centres

In 1982 training health centres offering residency programmes in family and community medicine were set up throughout Spain, chiefly in Catalonia, Castilla y Leon, Madrid and Andalusia (*unidades docentes de medicina familiar y comunitaria*). These health centres (*centros de salud docentes*) effectively provided an alternative system, with full-time salaried doctors working in primary care teams using well-developed A4 records for planned care of registered populations with defined limits (the health basic area), and organized continuing education. In 1984 a new law (*decreto de estructuras basicas de salud*) permitted development of these centres as a new general model for health centres, not necessarily attached to teaching. Implementation of this law has depended on widely varying initiatives in the different provinces of Spain.

By 1988 these new centres covered 20–30% of the Spanish population. Many are developing impressive programmes of proactive care for hypertension, diabetes and mental health as well as the more traditional fields of child health and antenatal care, with protocols devised jointly by general practitioners, specialists and community physicians.

Paradoxically, in the old industrial areas where the *am-*

*ambulatorio* system, and its more clinical and less administrative complement in private practice, are most developed, innovation seems to have been more difficult than in some of the less industrially developed regions. Thus Andalusia, with little industry, had 58 health centres by 1988 and opened another 67 centres in 1989; thus raising the proportion of the population served by the new model to 60%. This rapid development seems to be in some danger of outstripping its political base, in many ways weaker in Andalusia than in Catalonia, and some of the most innovative doctors are in danger of an isolation not at first apparent to outsiders.

Each health centre serves a registered population of 5000–30 000 patients, with an average of 20 000. This works out at a list size of 1500–3000 per whole-time doctor (working six hours a day). At one health centre in Catalonia (Suria) three doctors have taken great care to preserve personal responsibility through personal lists; though as in the UK this is not typical. However, the concept of continuing responsibility clearly exists and is being fought for. Though some health centres may still accept all comers informally, those I have seen in Andalusia and Catalonia insist on the need for registration as a first priority. Yet it would be easier to leave such administrative tasks until later, though by then it would be too late to define the population served. These centres had, on the whole, a more developed community orientation than the vast majority of British practices. General practitioners work a six or seven hour day plus some off-duty rota work, and are salaried. Salaries are related both to off-duty overtime worked and to populations at risk. About two-thirds of health centre general practitioners have been recruited through a competitive state examination; the remaining third have transferred from the *ambulatorios*. Sixty five per cent of all health centre general practitioners have postgraduate vocational training in family practice and community medicine, 5% have postgraduate training in hospital specialties, and the remainder have transferred from the *ambulatorios* and have no vocational training.

Most of the centres hold regular staff meetings and carry out educational work of some kind. About 80% of the articles in the Spanish primary care medical journal *Atencion Primaria* are written by doctors working in health centres. However, there are still major problems in health centres which could lead to their gradual reassimilation to the old pattern of care in the *ambulatorios*. These include persistent understaffing and overwork (excessive list size), unnecessary paperwork, slow development of team attitudes with both medical colleagues and nurses, and failure to develop personnel development programmes and community participation except in a few exemplary areas.

## Conclusions

Developments in Spanish primary care have important lessons for us in the UK. Clearly we have huge advantages in our long unbroken tradition of personal care for the whole population within a state service, and a relatively higher popular prestige for general practitioners in comparison with hospital specialists. Our service has on the whole been built from below by the initiatives of general practitioners themselves, and by their own organizations, notably the RCGP, whereas in Spain the initiatives have come from above, and few of the pioneers of primary care had a background in general practice.

However, we also have serious weaknesses. British general practitioners have for so long insisted on their own total autonomy, and governments have acquiesced in the consequent absence of any attempt to plan, coordinate, or measure the services we provide, that we now have real difficulty in taking the next step demanded by the continued advance of medical science; a move beyond passive response to patient demands, toward

active care of the health of our populations. The clumsy lurch toward planned and accountable care represented by the current contract seems more concerned with the appearance of progress than its reality.

The *ambulatorios* are a part-time, impersonal and industrialized system as bad as the worst UK general practice described in the Colling report in 1950 (*Lancet* 1950; 1: 555–585), and I am not convinced that attempts to reform it are an intelligent strategy when the alternative of full-time team care from health centres is already available, albeit in an early stage of development. However, competition between the various systems of providing primary care in Spain will no doubt continue, and there will eventually be outcome measures which should settle the issue, at least in principle. Though still in its infancy, the new Spanish health centre system is already a more advanced organism than anything we have developed on a community wide scale. It recognizes and uses the skills of public health and community medicine in the planned care of populations, with clinical targets and measures of their attainment. Our schools of community medicine teach these skills, but the NHS does not use them, except in a lopsided and generally ineffective way for containment of costs. We have a lot to learn from colleagues who have not abandoned the aim of advancing to a society more just, more democratic, and more effective than the one into which they were born, and who have understood the cost of defeat.

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There is little literature available in English on the Spanish primary care system. Primary care is well served by the monthly journal *Atencion Primaria* (Ediciones Doyma, Barcelona), whose articles include summaries in English. In preparing this paper, I have used the following:

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